Report to the Dirigo Health Agency

Dirigo Health
Savings Offset Payment:
Year 2 — Methodology and Data
Sources

MERCER

Government Human Services Consulting

Contents

EXECUTIVE SUMMARY	1
INTRODUCTION AND YEAR 1 SAVINGS OFFSET PAYMENTS	1
COST SAVINGS INITIATIVES — YEAR 2 METHODOLOGY	
Hospital Savings Initiatives	2
Uninsured Savings Initiatives	
Certificate of Need and Capital Investment Fund Savings Initiatives	
Health Care Provider Fee Savings Initiatives	5
INTRODUCTION — SAVINGS OFFSET PAYMENT METHODOLOGY YEAR 2	6
OVERVIEW AND BACKGROUND	6
YEAR 2 SAVINGS OFFSET PAYMENT METHODOLOGY	7
Initiatives for Cost Savings Measurement	7
Methodology and Assumptions	
Organization of Report and Data Availability	9
HOSPITAL SAVINGS INITIATIVES	12
Introduction	12
YEAR 1 METHODOLOGY	12
YEAR 2 METHODOLOGY AND DATA SOURCES	15
Cost per Case-Mix Adjusted Discharge	15
UNINSURED SAVINGS INITIATIVES	18
Introduction	18
YEAR 1 METHODOLOGY	19
YEAR 2 METHODOLOGY AND DATA SOURCES	19
Uninsured and Under-insured: Reduction of Bad Debt and Charity Care	19
MaineCare Adult Expansion	21
MaineCare Woodwork Effect	22
CERTIFICATE OF NEED AND CAPITAL INVESTMENT FUND SAVINGS INITIATIVES	24
Introduction	24
YEAR 1 METHODOLOGY	24
YEAR 2 METHODOLOGY AND DATA SOURCES	
CON/CIF	25
HEALTH CARE PROVIDER FEE SAVINGS INITIATIVES	27
Introduction	27
Year 1 Methodology	27
YEAR 2 METHODOLOGY AND DATA SOURCES	28
Hospital and Physician Fee Initiatives	28

Executive Summary

Introduction and Year 1 Savings Offset Payments

The Dirigo Health Reform Act includes a provision for a Savings Offset Payment (SOP), designed to reflect the impact of various Dirigo and Dirigo-related savings initiatives to reduce the rate of growth in the health care system in the State of Maine (Maine). The Dirigo Health Reform Act was approved by the Governor of Maine in June 2003. The first year of operations began June 2003 and concluded May 2004, with the first year of enrollment commencing January 2005 and ending December 2005. Per the terms of the Dirigo Health Reform Act, the Year 1 Savings Offset Payment (SOP) methodology had to cover multiple time periods to address the various time periods associated with each of the Year 1 initiatives. The process to determine the savings methodologies began in the fall of 2004 and continued into 2005. The final savings methodologies were determined in October 2005. Please refer to the final report of the Superintendent of the Bureau of Insurance at http://www.state.me.us/pfr/ins/ins/05700Dirigo.htm.

The Year 2 savings methodologies and SOP amount are required to be completed by April 1, 2006, in compliance with Title 24-A M.R.S.A §6913. However, not all the relevant data necessary to calculate the Year 2 savings amounts and SOP will be available until July 1, 2006, at the earliest. The unavailability of this data makes it impossible to determine the savings amount at this time; however, the methodologies for calculation can be established.

Mercer Government Human Services Consulting (Mercer) has been engaged by the Dirigo Health Agency (DHA) to develop the Year 2 savings methodologies and ensure that they are consistent, as reasonable as possible given the absence of data, and are structured to adequately measure the impact of the initiatives on the rate of growth in the health care system in the State. In general, Mercer relied upon the Year 1 methodologies

reviewed and approved by the Superintendent of Insurance (Superintendent). Where appropriate, Mercer made adjustments to the methodology in Year 2 to improve its ability to determine the impact of the Dirigo initiatives upon the health care system in the State.

Mercer is not an expert in Medicare Cost Reports (MCRs) or the State's Certificate of Need/Capital Investment Fund (CON/CIF) process. As a result, for the Year 2 hospital savings initiatives, Mercer relied on the work done by Dr. Nancy Kane of the Harvard School of Public Health during the Year 1 calculations, as well as State employees identified by the State as having particular expertise in MCRs. For the Year 2 CON/CIF initiatives, Mercer relied on the work of State employees identified by the State as having particular expertise in CON/CIF initiatives. For savings initiatives using the MCRs and CON/CIF data, Mercer and the State experts worked collaboratively to determine a reasonable methodology for determining what savings, if any, resulted from the Dirigo initiatives. Mercer was also hired by the DHA to compile the savings methodologies, summarize them into a single report, and present that report to the DHA and the DHA Board of Directors (Board) as part of an adjudicatory hearing process. This report represents that summary. The Board then has the responsibility to determine the methodology and actual SOP amounts forwarded to the Superintendent of Insurance for final review.

The following savings methodologies were developed using the following standards:

- actuarial science best practices;
- reasonableness of the assumptions used in the methodologies; and
- adherence to the guidelines provided by the Superintendent in regards to the Year 1 methodologies.

Mercer developed the methodologies with the intent that readily available, industry-standard data sources would be used for the calculations. The following summary of initiatives and the savings methodologies outlines the methodology that will be employed when the necessary data becomes available.

Cost Savings Initiatives — Year 2 Methodology

Hospital Savings Initiatives

This section outlines the voluntary targets that were established for hospitals as a way to generate savings to payers and to the health care system. For hospital fiscal years ending in 2004 and 2005, the Maine Hospital Association (MHA), acting on behalf of its member hospitals, agreed to a voluntary limit for increases in cost per case-mix adjusted discharge (CMAD) of 4.5 percent. (See the attached MHA newsletter)

Cost per Case-Mix Adjusted Discharge

CMAD measures the cost of inpatient and outpatient services provided by hospitals and their subsidiaries. Reducing the rate of increase in the cost of services reduces the need for payer rate increases and results in savings to the entire health care system.

The CMAD methodology for savings determination combines hospital fiscal year (HFY) data for each hospital to adjust each hospitals' cost per discharge to a State fiscal year (SFY) basis. Appropriate revenues and expenses will be summed across all hospitals to determine system-wide revenues and expenses. Then Statewide CMAD figures for SFY00 through SFY05 will be determined. A projected system-wide SFY03 will be estimated by projecting the SFY00 CMAD forward, using the hospital market basket index (HMBI) for each year. A pre-Dirigo annual rate of growth in CMAD exclusive of HMBI increases will be determined using SFY00 and SFY03 CMAD information. A projected SFY05 CMAD will be determined using the actual SFY03 CMAD, HMBI trends, and the annual rate of growth above HMBI inflation. SFY05 projected Statewide CMAD will be compared with the actual Statewide SFY05 CMAD. This final aggregate savings amount, positive or negative, will be multiplied by the total Maine hospital CMAD in SFY05 to determine the final savings amount. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the CMAD calculation is not available, so savings amounts cannot be calculated at this time.

Uninsured Savings Initiatives

The uninsured savings stem from the reduction in bad debt (BD) and charity care (CC) that will result from taking previously uninsured and under-insured individuals and providing them with health coverage. As these individuals become insured, hospitals and other health care providers will no longer incur the BD and CC associated with their health care and will not need to cost-shift to private payers to cover the cost of their previously non-reimbursed health care. In addition, uninsured savings can result from a "woodwork effect" (WW Effect) due to expansions in eligibility. These expansions in eligibility can come from either new MaineCare enrollment or new MaineCare eligibility. The "WW Effect" occurs when major health care reform initiatives are introduced, causing people to "come out of the woodwork" to enroll. Increased enrollment in the new program and an overall increase in the Medicaid program enrollment take place due to the increased publicity and awareness of the value of health insurance.

Bad Debt and Charity Care Savings

The methodology for determining savings for the uninsured and under-insured will require determining the amount of BD and CC costs attributable to previously uninsured

and under-insured that are now in DirigoChoice. These amounts will be converted to a cost basis and adjusted for BD/CC due to cost-sharing. The average per member per month (PMPM) cost for those that were both previously uninsured and under-insured will be calculated. Member months (MMs) will be determined and the PMPM costs adjusted for those that used hospital-based services. Savings are determined by multiplying the PMPM by the estimated number of MMs of the previously uninsured or under-insured. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

MaineCare Adults Expansion

The methodology to determine the savings for this initiative begins with determining the increase in enrollment, measured in MMs, in the MaineCare Adults Expansion. This will be combined with the PMPM cost for the uninsured, adjusted for cost-sharing differences, and those differences established in the assumed future BD/CC expenditures. The product of these differences and the enrollment increases will account for the savings. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

Woodwork Effect Savings

The methodology to determine the savings derived from the "WW Effect" begins with determining the portion of increase in enrollment, measured in MMs, in the overall MaineCare program that is attributable to Dirigo. This will be combined with the PMPM cost for the uninsured, adjusted for cost-sharing differences, and those differences established in the assumed future BD/CC expenditures. The product of these differences and the enrollment increases will account for the savings. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the uninsured calculations are not available, so savings amounts cannot be calculated at this time.

Certificate of Need and Capital Investment Fund Savings Initiatives

The methodology for determining cost savings will need to determine the reductions in spending for hospital and non-hospital infrastructure that resulted from the CON moratorium and CIF limits. CIF amounts are imposed by calendar year (CY); however, the methodology for the savings calculations will be determined by SFY in compliance with the other savings determinations and the CON.

The methodology will begin with categorizing CON/CIF projects into pre- and post-Dirigo time frames. An average cost per project will be determined and an estimated

average third year operating cost per project in the post-Dirigo time period established. The average cost per project will then be applied to the ratio of projects by project milestone and savings calculated. The project milestone ratio will be determined by comparing the projects at each milestone in the CON/CIF process in the pre-Dirigo time period to the post-Dirigo time period. The addition of the present value of the amounts saved on each project will represent the savings generated from the CON/CIF initiatives. A similar methodology will be followed for non-hospital CON projects. Interest will be applied to the savings amount to put it on a consistent time period with the other savings calculations.

As of the writing of this methodology report, all of the data for the CON/CIF calculations are not available, so savings amounts cannot be calculated at this time.

Health Care Provider Fee Savings Initiatives

Hospitals and other health care providers must seek to meet their annual financial requirements using a variety of funding sources. Over the long term, differences between financial requirements and payments by various payers may be shifted to the private sector payers, whose rates are negotiable (unlike the public sector — Medicare and Medicaid — where rates are determined by the public payers), resulting in higher rate increases to private payers. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives. Therefore, the need for cost increases to other payers will be reduced when this additional cash is received by hospitals and physician providers, resulting in savings to the system.

Hospital Fee and Physician Fee Initiatives

In accordance with the direction of the Superintendent, the hospital fee initiative methodology for calculating savings will calculate the sum of the time value of borrowed funds for the budgeted increase in State's Prospective Interim Payments (PIP) for CY06. The physician fee initiative methodology, in accordance with the direction of the Superintendent, will determine the available savings as based on budgeted State payments to eligible physicians during CY06.

Introduction — Savings Offset Payment Methodology Year 2

Overview and Background

Chapter 87 of Title 24-A of the Maine Insurance Code, Dirigo Health outlines the primary requirements and guidelines for operation and management of Dirigo Health. One of the key requirement calls for measuring the aggregate cost savings on an annual basis that result from Dirigo and its various directly and indirectly related components. Per the terms of the Dirigo Health Reform Act, the Year 1 Savings Offset Payment (SOP) methodology had to cover multiple time periods to address the various time periods associated with each of the Year 1 initiatives. The process to determine the savings methodologies began in the fall of 2004 and continued into 2005. The final savings methodologies were determined in October 2005. Please refer to the final report of the Superintendent of the Bureau of Insurance's at http://www.state.me.us/pfr/ins/ins05700Dirigo.htm.

The Year 2 savings methodologies and SOP are required to be completed by April 1, 2006, in compliance with Title 24-A M.R.S.A §6913. However, all of the relevant data necessary to calculate Year 2 savings SOP will not be available until July 1, 2006, at the earliest. The unavailability of this data makes it impossible to determine the savings amount and SOP at this time; however, the methodologies for calculation can be established.

Mercer Government Human Services Consulting (Mercer) has been engaged by the Dirigo Health Agency (DHA) to develop the Year 2 savings methodologies and ensure that they are consistent, as reasonable as possible given the absence of data, and are structured to adequately measure the impact of the initiatives on the rate of growth in the

health care system in Maine. In general, Mercer relied upon the Year 1 savings methodologies reviewed by and approved by the Superintendent of Insurance (Superintendent). Where appropriate, Mercer made adjustments to the savings methodologies in Year 2 to improve its ability to determine the impact of the Dirigo initiatives upon the health care system in the State of Maine (Maine).

Mercer is not an expert in Medicare Cost Reports (MCRs) or the State's Certificate of Need/Capital Investment Fund (CON/CIF) process. As a result, for the Year 2 hospital savings initiatives, Mercer relied on the work Dr. Nancy Kane, a professor of Management at the Harvard School of Public Health, completed during the Year 1 calculations, as well as State employees identified by the State as having particular expertise in MCRs. For the Year 2 CON/CIF initiatives, Mercer relied on the work of State employees identified by the State as having particular expertise in CON/CIF. For savings initiatives using the MCRs and CON/CIF data, Mercer and the State experts worked collaboratively to determine a reasonable methodology for determining what savings, if any, resulted from the Dirigo initiatives. Mercer was also hired by the DHA to compile the savings methodologies, summarize them into a single report, and present that report to the DHA and the DHA Board of Directors (Board) as part of an adjudicatory hearing process. This report represents that summary. It is then up to the DHA Agency and Board to determine the savings methodologies and savings amount to be forwarded to the Superintendent of Insurance.

The savings methodologies in this report were developed using the following standards:

- actuarial science best practices;
- reasonableness of the assumptions used in the methodologies; and
- adherence to the guidelines provided by the Superintendent in regards to the Year 1 methodologies.

Mercer developed the methodologies with the intent that readily available, industry-standard data sources would be used for the calculations.

Year 2 Savings Calculation Methodology

As indicated above, the relevant data necessary to calculate Year 2 savings amount and SOP will not be available until July 1, 2006 at the earliest. The unavailability of this data makes it impossible to determine the savings at the time of this report; however, the methodologies for calculation can be created. The following initiatives are included.

Initiatives for Cost Savings Measurement

- Hospital Savings Initiatives
 - Hospital System Cost Per Case Mix-Adjusted Discharge (CMAD)
- Uninsured Savings Initiatives

- Uninsured Reduction of Bad Debt (BD) and Charity Care (CC)
- Under-Insured Reduction of BD and CC
- MaineCare Eligibility (MaineCare Adult Expansion) Enrollment
- MaineCare Increased (MaineCare Woodwork Effect) Enrollment
- Uninsured Private Woodwork (Private WW) Enrollment
- Certificate of Need (CON) and Capital Investment Fund (CIF) Savings Initiatives
 - Hospital CON Moratorium and CIF limits
 - Non-Hospital CON Moratorium and CIF limits
- Health Care Provider Fee Savings Initiatives
 - Hospital Fee Initiatives
 - Physician Fee Initiatives

The Year 1 savings methodology included a calculation of the savings achieved by hospitals through a voluntary Consolidated Operating Margin (COM) limit and for insurance carriers through a Voluntary Underwriting Gain (VUG) limit. There has been no legislation re-authorizing the COM or VUG limits, nor have hospitals or carriers voluntarily agreed to continue the COM or VUG limits, respectively. Therefore, there is no COM or VUG calculation in the Year 2 savings methodology.

Methodology and Assumptions

Guiding Principles

In developing the methodology for calculating the Year 2 aggregate measurable savings, the following principles guided our process:

- Initiatives will be related to the Dirigo Health Reform Act, consistent with Public Law (PL) 2003, Chapter 469 and the methodologies themselves must be consistent with PL 2003 Chapter 469.
- To the extent possible, methodologies for Year 2 will be consistent with the guidelines provided by the Superintendent in regards to the Year 1 methodologies. Where appropriate, Mercer made changes to the guidelines suggested by the Superintendent and noted our changes accordingly.
- Initiatives are primarily voluntary. It is the role of the marketplace to voluntarily comply with savings targets and to recapture savings in price negotiations.
- Data sources, when available, must be readily available, verifiable and auditable, and to the extent possible, used for multiple purposes to ensure the accuracy of the underlying data.
- The savings, once calculated, should not be overstated, nor should they be understated: the methodology must be reasonable and appropriately measure the impact of Dirigo on the rate of growth in the health care system.
- The methodology for savings calculations must be transparent, meaning the savings are calculated using the data available, the methodologies as best as

- possible laid out in this report, and savings amounts verified through worksheets contained in a final report when data is available.
- When calculated, the savings will be used to sustain DirigoChoice at no additional costs.

Organization of Report and Data Availability

The remainder of this document contains chapters that outline and explain each of the above initiatives. The methodologies for cost savings that are presented here have been developed in the absence of much of the necessary data. As a result, the final methodologies may require some adjustments when the final data is utilized.

The following table depicts the data availability by initiative at this time.

CMAD* Data Elements

CIVIAD Data Liettettis			
Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY99 to HFY05	Currently Available
Discharges and Case-Mix Index by Hospital		HFY ending 9/30/05 and 12/31/05	July 2006
Expense and Revenue Reports by Hospital	MCRs	HFY99 to HFY05	Currently Available
Expense and Revenue Reports by Hospital		HFY ending 9/30/05 and 12/31/05	July 2006
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY99 to HFY04	Currently Available
Hospital Tax Allocation		HFY ending 9/30/05 and 12/31/05	July 2006

^{*}Pending request new/updated filings after 7/05 for the period HFY99–04. Pending request to obtain Medicare Cost Reports currently available for HFY05 and HFY06.

MaineCare Uninsured/Under-Insured/WW Effect Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey — Updated	1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare Adult Expansions	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006

CON/CIF Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	SFY99 to CY05	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	1/1/06 to 6/30/06	July 2006

Hospital Fee Initiatives Data Elements

toopital 1 00 illitiati 100 Bata Elomonto			
Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Historical Settlement Amount — Paid 9/30/2005		Paid through 9/30/2005	Currently Available
Current Settlement Amount — Budgeted	State Budget	SFY06 and SFY07	Currently Available
Increase in PIP Payments — Budgeted	State Budget	CY06	Currently Available

Physician Fee Initiatives Data Elements

Data Elements	Data Source	Time Period	Date Available	
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available	
Increase in Fee Schedule Payments — Budgeted		CY06	Currently Available	

Data Elements Applicable to Multiple Initiatives

Data Elements	Data Source	Time Period	Date Available
Short-Term Interest Rate	Treasury Bond Yield Rates		July 2006 for midpoint of CY06

Hospital Savings Initiatives

Introduction

This section outlines the voluntary targets that were established for hospitals to generate savings to payers and to the health care system. CMAD measures the cost to the hospital of services in hospitals and their subsidiaries. Reducing the rate of increase in the cost to the hospital of services reduces the need for hospitals to increase the rates they charge to payers and results in savings to the entire health care system.

Year 1 Methodology

Cost per Case-Mix-Adjusted Discharge

Dr. Nancy Kane, a professor of Management at the Harvard School of Public Health, calculated the CMAD savings calculation for Year 1. The following is a brief description of the savings methodology she employed to estimate Year 1 savings for CMAD voluntary target. For a more complete description of Dr. Kane's Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, *Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).*

To determine if savings resulted from the voluntary CMAD target, it was necessary to first blend each hospital's fiscal year (HFY) data together to create a cost per discharge figure for each hospital on a state fiscal year 2000 (SFY00) basis. Then each hospital's projected SFY03 cost per discharge was estimated from SFY00 costs by trending forward the SFY00 cost per discharge amounts by the annual HMBI increases. The projected SFY03 costs were compared to the actual SFY03 (blended) costs to determine each

hospital's cost per discharge growth rate above inflation. SFY04 CMAD was estimated using a hospital's cost growth rate above inflation and compared to the hospital's actual SFY04 (blended) cost per discharge. Savings were calculated when the difference between the SFY04 estimated cost per discharge and the actual SFY04 (blended) cost per discharge was positive. Summing this cost per discharge savings across all discharges and all hospitals yielded total savings for the voluntary CMAD target.

There are 4 potential scenarios where savings could have occurred in Year 1 for a hospital, using the Year 1 voluntary CMAD limit of 3.5% Mercer's approach in Year 1 was conservative and only estimated savings derived from the first two scenarios:

- 1. Hospital baseline trend was above 3.5% and SFY/04 trend was below the baseline. Positive savings can be directly measured in Scenario #1.
- 2. Hospital baseline trend was below 3.5% and SFY04 trend was below the baseline. Positive savings can be directly measured in Scenario #2
- 3. Hospital baseline trend was above 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #3, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.
- 4. Hospital baseline trend was below 3.5% and SFY04 trend was above the baseline. For positive savings to be measured in Scenario #4, an indirect counter-factual analysis would have been necessary to determine if the SFY04 trend would have been higher in the absence of Dirigo.

Table 1 depicts the methodology used to determine the impact of voluntary CMAD limits in Year 1.

Table 1. CMAD - Year 1 Methodology

Savings	SFY04 trend is lower than baseline trend	SFY04 trend is higher than baseline trend
Positive	A) Scenarios 1 and 2 above	C) Normally occurring fluctuations in CMAD
Negative	B) Normally occurring fluctuations in CMAD	D) Scenarios 3 and 4 above

Table 2 compares the Superintendent's guidelines for the Year 1 methodology to Mercer's Year 1 methodology.

Table 2. CMAD - Comparison of Year 1 Methodologies

Table 2. CMAD - Compa	arison of Year 1 Methodologies
Methodology	Comparison
Mercer's Year 1 Methodology	Mercer's Year 1 methodology estimated savings only from Box A; positive savings as a result of measurable reductions in CMAD. The testimony during the Year 1 adjudicatory hearing clearly established that Dirigo was the primary driver of positive savings in Box A, representing Scenarios 1 and 2. The Testimony also clearly established that Dirigo was <u>not</u> the primary driver of negative savings in Box D, representing Scenarios 3 and 4.
	In fact, the testimony established that nothing in the Dirigo legislation would cause an increase in costs (and thus negative savings) as measured by Box D. Mercer assumed that, at a minimum, a similar relationship existed between Boxes B and C. Mercer assumed, at a minimum, the savings component in Box B (which is negative overall) would be at least as large in magnitude as the savings component in Box C (which is positive overall).
	This assumption was borne out as reasonable, as testimony clearly established that Dirigo was the primary driver behind positive savings in the system and had no impact on negative savings. Thus, Mercer's methodology, based on positive savings from Box A and implicitly accounting for random fluctuations by assuming Boxes C and D at a minimum cancel each other out, was reasonable.
Superintendent's Year 1 Methodology	The Superintendent was concerned with controlling for normally occurring fluctuations and so included both Box A and D in an attempt to control for those fluctuations and determine savings due to Dirigo. The Superintendent's methodology effectively provides equal weights to the Dirigo impacts in Box A and Box D. However, as noted above, the testimony clearly showed this was not the case — Dirigo was the driver in Box A but had no impact on Box D.
	Thus, the Superintendent's methodology of netting Boxes A and D unnecessarily reduces the savings attributed to Dirigo, contrary to the testimony, in an attempt to control for normally occurring fluctuations in CMAD.

Year 2 Methodology and Data Sources

Cost per Case-Mix Adjusted Discharge

Using the Superintendent's decision on Year 1 savings as guidance, Mercer has modified the CMAD savings methodology for Year 2.

Methodology

Table 3 describes Mercer's Year 2 CMAD methodology based on input from the Superintendent.

Table 3. CMAD - Description and Comparison of Mercer's Year 2 Methodology to Year 1

Methodology	Description and Comparison to Year 1
Mercer's Year 2 Methodology	To address the Superintendent's concern about Mercer's Year 1 methodology not factoring in normally occurring fluctuations in CMAD, Mercer has designed a methodology for Year 2 that includes all four Boxes: A, B, C, and D. In Mercer's Year 2 methodology, we apply Year 1's approach to determining individual hospital CMAD experience and then go a step further in Year 2 by summing all hospitals' experience to determine a Statewide aggregate CMAD pre- and post-Dirigo.
	This additional step of summing all of the hospitals' individual CMAD experience includes <i>all</i> of the experience — Boxes A, B, C, and D. Mercer's Year 2 methodology for CMAD addresses the concerns raised by the Superintendent by controlling not only for positive savings (Box A), but also for normally occurring fluctuations (Boxes B and C), as well as negative savings (Box D).
	Finally, to address a concern raised by the Superintendent about determining savings across inconsistent time periods, Mercer will apply an interest factor to adjust the savings to a consistent present value.

Below is the process Mercer will take in order to determine if there are overall aggregate CMAD savings in Year 2:

- 1. Combine HFY data for each hospital as necessary to put all hospitals on a SFY basis;
- 2. Sum the appropriate revenues and expenses across all hospitals to determine system-wide revenues and expenses, then calculate Statewide CMAD figures for SFY00 through SFY05;
- 3. Project the SFY03 CMAD system-wide from the SFY00 CMAD trended forward using the HMBI for each year to SFY03; compare this projected SFY03 CMAD to the actual SFY03 CMAD and calculate the pre-Dirigo annual rate of increase in beyond inflation in the HMBI;

- 4. Project the SFY05 CMAD using the actual SFY03 CMAD, HMBI trends, and the pre-Dirigo annual rate of growth above inflation;
- 5. Compare the projected Statewide SFY05 CMAD with the actual Statewide SFY05 CMAD; savings are calculated as the difference of the projected system-wide figure compared to the actual;
- 6. Multiply the savings per CMAD by the total Maine hospital CMAD in SFY05 to arrive at our final savings number; and
- 7. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

Table 4 below describes the data required to determine the impact of the Year 2 voluntary limit on CMAD.

Table 4. CMAD* Data Elements

Table 4. CWAD Data Elements				
Data Elements	Data Source	Time Period	Date Available	
LIMDI	Clabal Inciabt/DDI	CEV00 to CV0C	Commonthy Associable	
HMBI	Global Insight/DRI	SF 100 to C 106	Currently Available	
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY99 to HFY05	Currently Available	
Discharges and Case-Mix Index by Hospital	Maine Health Data Organization	HFY ending 9/30/05 and 12/31/05	July 2006	
Expense and Revenue Reports by Hospital	MCRs	HFY99 to HFY05	Currently Available	
Expense and Revenue Reports by Hospital	MCRs	HFY ending 9/30/05 and 12/31/05	July 2006	
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY99 to HFY04	Currently Available	
Hospital Tax Allocation	Audited Financial Statements and State/MHA Information	HFY ending 9/30/05 and 12/31/05	July 2006	

^{*}Pending request new/updated filings after 7/05 for the period HFY99–04. Pending request to obtain Medicare Cost Reports currently available for HFY05 and HFY06.

Uninsured Savings Initiatives

Introduction

In this section we will discuss the potential for uninsured and under-insured savings due to the reduction in BD and CC and the "WW Effect" for MaineCare individuals. The uninsured savings stem from the reduction in BD and CC that will result from taking previously uninsured and under-insured individuals and providing them with health coverage. As these individuals become insured with credible coverage, the hospitals and other health care providers will no longer incur the BD and CC associated with their health care and, therefore, will not need to cost-shift to private payers to cover the cost of their previously non-reimbursed health care.

The "WW Effect" happens when major health care reform initiatives are introduced, causing people to "come out of the woodwork" to enroll. In addition to increased enrollment in the new program, states see an increase in the Medicaid program due to the increased publicity and awareness of the value of health insurance. The Dirigo statute states savings are to be measured due to "...any increased enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004." Increased enrollment can be due to eligibility changes, such as the MaineCare Adult Expansion group (150 – 200% of Federal Poverty Level) that began enrollment in Spring of 2005, or increased enrollment can due to the number of MaineCare eligibles increasing in general as a result of Dirigo.

The "WW Effect" on the private insurance market will be analyzed once data is available.

Year 1 Methodology

In the Year 1 savings calculation, Mercer estimated the savings generated by those people that were once uninsured or under-insured and now insured under Dirigo. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, *Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).*

To determine if there were savings from the uninsured and under-insured receiving health insurance due to Dirigo, Mercer projected the BD/CC PMPM costs, adjusting for those who enroll into Dirigo in the first year and reflecting their relative risk, and multiplying by those that are now in Dirigo who used to be incurring the BD/CC costs.

The MaineCare "WW Effect" was calculated to measure the savings generated due increased MaineCare enrollment as a result of the publicity around the Dirigo program. This was calculated in manner similar to the uninsured savings calculation. Any "WW Effect" on the private insurance market was postponed until data was available.

Year 2 Methodology and Data Sources

Uninsured and Under-insured: Reduction of Bad Debt and Charity Care

Using the methodology approved by the Superintendent for the Year 1 SOP calculation as a guide, Mercer will determine savings in Year 2 using the following methodology.

Methodology

- 1. Determine the amount of BD and CC costs attributable to previously uninsured and under-insured individuals that are now in DirigoChoice. Using the above data, BD and CC spent in hospitals and spent with other providers will be added to determine a total BD and CC dollar amount. Hospitals report data on differing HFYs, so adjustments will be made to put all data on a consistent CY time period. This will be further split by the uninsured and under-insured. HMBI trend will be applied to these costs to estimate BD and CC in CY06, assuming the absence of the DirigoChoice program;
- 2. Adjust the BD and CC dollar amount in Step 1 from a hospital charges basis to convert it to an estimated cost basis using the assumption from information in the MCRs. An additional adjustment will be made to account for possible BD/CC due to cost-sharing. That is, providers who render services to individuals with higher deductible plans still face the risk of not being able to collect in the entirety for services they perform.

- 3. Calculate the average PMPM cost for those that were previously uninsured and under-insured by using BD and CC costs developed in Step #1 and Step #2 and dividing by MMs of those uninsured and those under-insured. The MMs will be determined by taking the uninsured and under-insured individuals and multiplying by 12 months.
- 4. Adjust the PMPM calculated in Step #3 by applying an adjustment factor based on the Claims Probability Distribution Table for those that used hospital-based services, previously incurring BD and CC.
- 5. Multiply the PMPM in Step #4 by the estimated MMs of those previously uninsured or under-insured to arrive at savings.
- 6. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

Table 5 describes the data elements that will be necessary to determine the impact of the uninsured savings initiatives upon the health care system in Maine.

Table 5. Uninsured/Underinsured Data Elements

Tuble of Offinisarea/Office	erinsured Data Elements		
Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey — Updated	1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006

MaineCare Adult Expansion

To determine the impact of the MaineCare Adult Expansion, Mercer will use the methodology below.

Methodology

- 1. Determine increase in enrollment in the MaineCare Adult Expansion;
- 2. Using the MMs from Step #1 and the PMPMs developed above for the uninsured, adjust for cost-sharing differences and differences in assumed future BD/CC expenditures;
- 3. Calculate savings by multiplying Step #1 and Step #2 together; and
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

The source data used in this calculation will be most of the same source data used in the uninsured and under-insured calculations. An additional data source will be used to calculate the MaineCare net change in enrollment in the time frames used. Month by month counts of MaineCare enrollees by eligibility category will be prepared by the Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine. Also, a cost-to-charge ratio developed from MCR information will be used.

Table 6. MaineCare Adult Expansion Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available

Data Elements	Data Source	Time Period	Date Available
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey — Updated	1/1/05 to 6/30/05	Currently Available
Enrollment in MaineCare Expansions	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006

MaineCare Woodwork Effect

To determine the portion of the increase in MaineCare enrollment due to the Dirigo program, Mercer will use the methodology detailed below.

Methodology

- 1. Determine increase in enrollment in the MaineCare prior to Dirigo and compare that rate of increase after Dirigo; determine if Dirigo has impacted the rate of enrollment growth and if so, convert that impact to an estimated annual MM figure based on annual growth rates;
- 2. Using the MMs from Step #1 and the PMPMs developed above for the uninsured, adjust for cost-sharing differences and differences in assumed future BD/CC expenditures;
- 3. Calculate savings by multiplying Step #1 and Step #2 together; and
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

The source data used in this calculation will be most of the same source data used in the uninsured and under-insured calculations. An additional data source will be used to calculate the MaineCare net change in enrollment in the time frames used. Month by month counts of MaineCare enrollees by eligibility category will be prepared by the Institute for Health Policy, Edmund S. Muskie School of Public Service, University of Southern Maine. Also, a cost-to-charge ratio developed from MCR information will be used.

Table 7. MaineCare WW Effect Data Elements

Table 7. MaineCare WW Effect Data Elements				
Data Elements	Data Source	Time Period	Date Available	
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available	
Muskie Health Insurance Survey	Muskie School of Public Health, USM	CY02	Currently Available	
Claims Probability Distribution Table	Mercer Government Human Services Consulting	Not Applicable	Currently Available	
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY99 to HFY04	Currently Available	
BD and CC Amounts	Audited Financial Statements, IRS Form 990s, and MCRs	HFY ending 9/30/05 and 12/31/05	July 2006	
Number of Uninsured Mainers	Census Data	CY03 to CY05	Currently Available	
Number of Under-Insured Mainers	Census Data	CY03 to CY05	Currently Available	
Number of Previously Uninsured and Under-Insured Mainers that are now in Dirigo	DirigoChoice Member Survey C Updated	1/1/05 to 6/30/05	Currently Available	
Enrollment in MaineCare	MaineCare Enrollment Reports	SFY04 to SFY06	July 2006	

Certificate of Need and Capital Investment Fund Savings Initiatives

Introduction

This section outlines the cost savings that result from the reductions in operation spending. This includes savings from the CON Moratorium and CIF, for both hospitals and non-hospitals. CON and CIF are measures of spending for hospital and non-hospital providers. As this spending is reduced, the need for payer rate increases is reduced: the State imposed a moratorium on spending for new buildings and equipment for one year, starting May 1, 2003, and imposed a limit to all subsequent new spending to an annually adjusted amount within the CIF. CIF amounts are imposed by CY; however, the following savings calculations were determined by SFY in compliance with the other savings determinations and the CON.

Year 1 Methodology

The methodology for calculating the savings in relation to the CON/CIF initiatives for Year 1 compared the third year operating costs for all projects pre- and post-Dirigo. Using a lag table to show the run-out of project costs over an assumed useful project life of 3 years for all hospital and non-hospital projects, Mercer estimated the savings due to the reduction in projects resulting from the CON moratorium and CIF limitation. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, *Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).*

Year 2 Methodology and Data Sources

Certificate of Need and Capital Investment Fund Savings Initiatives

After reviewing comments made by the Superintendent for the Year 1 savings calculation, and consulting with State CON/CIF staff, Mercer has developed the following methodology for this calculation.

Methodology

- 1. Using the data send from the State, separate the CON/CIF projects in pre-Dirigo (07/01/1998–04/30/2003) and post-Dirigo (05/01/2003–06/30/2006).
- 2. Using the third year operating cost from the pre-Dirigo data, determine an average cost per project to use in the savings calculations.
- 3. Apply HMBI trend to the average third year operating cost per project to estimate average third year operating cost per project in the post-Dirigo time period.
- 4. Apply the average cost per project to the differences in the project milestone ratios. The project milestone ratios will be determined by comparing the hospital and non-hospital CON and CIF activity by milestone in the pre-Dirigo time period to the post-Dirigo time period. The savings will be estimated on a milestone-by-milestone basis.
- 5. Adjust each milestone savings estimate calculated in Step #4 to a present value savings dollar amount. The addition of the present value of each savings will be the savings generated from the CON/CIF initiatives. A similar methodology will be followed for non-hospital CON projects.
- 6. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

As it becomes available, the State will supply data on the volume of Letters of Intent, Technical Assistance Sessions, Applications, and Approvals for all hospital and non-hospital CON projects for the time period 07/01/1998–06/30/2006. We will also use the HMBI trends to project the data into future time periods.

Table 8. CON/CIF Data Elements

Table of Colifon Pata Elemente			
Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available

Data Elements	Data Source	Time Period	Date Available
CON/CIF Project Filings and Cost Information	State CON Department	SFY99 to CY05	Currently Available
CON/CIF Project Filings and Cost Information	State CON Department	1/1/06 to 6/30/06	July 2006

Health Care Provider Fee Savings Initiatives

This section outlines the cost savings from reductions in cost shifting that result from increased funding to hospitals and other providers. Hospitals and other health care providers must meet their annual financial requirements using a variety of funding sources. Over the long term, differences between financial requirements and payments by various payers may be shifted to the private sector payers, whose rates are negotiable (unlike the public sector — Medicare and Medicaid — where rates are determined by the public payers), resulting in higher rate increases to private payers. The State will make additional payments to hospitals and physicians as a result of the Dirigo Health Reform Act and its related initiatives, to recognize differences identified by the Maine Hospital Commission in its review of the funding of the Medicaid program. Therefore, the need for cost increases to other payers will be reduced when this additional cash is received by hospitals and physician providers, resulting in savings to the system.

Year 1 Methodology

Hospital Fee Initiatives

The methodology for calculating the savings in relation to the hospital fee initiatives for Year 1 included determining the amount of additional funding and the time value of money involved with getting the money earlier than expected. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, *Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).*

Physician Fee Initiatives

The methodology for calculating savings for the increase in the physician Medicaid fee schedule was developed by reviewing payments to be made 07/01/05–12/31/06. For a more complete description of the Year 1 methodology, please refer to Mercer's report on the Year 1 Savings Offset Payment Calculations, *Dirigo Health Savings Payment: Year 1 Savings Offset Methodology and Calculations, November 2005 (Revised).*

Year 2 Methodology and Data Sources

Hospital and Physician Fee Savings Initiatives

To determine the impact of the hospital and physician fee initiatives, Mercer will use the methodology below for Year 2.

Methodology

- 1. Confirm hospital Prospective Interim Payment (PIP) increases and increased physician payments to be paid in CY06.
- 2. Calculate the time value of receiving the PIP increases early so hospitals do not have to borrow or use other funds. Use an updated interest rate to reflect the appropriate time periods.
- 3. Calculate the amount of additional physician money available. Add #2 and #3 to determine total savings for this initiative.
- 4. Apply interest to the savings amount to put it on a consistent time period with the other savings calculations.

Data

Table 9.a. Hospital Fee Initiative Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Historical Settlement Amount — Paid 9/30/2005		Paid thru 9/30/2005	Currently Available
Current Settlement Amount — Budgeted	State Budget	SFY06 and SFY07	Currently Available
Increase in PIP Payments — Budgeted	State Budget	CY06	Currently Available

Table 9.b. Physician Fee Initiative Data Elements

Data Elements	Data Source	Time Period	Date Available
НМВІ	Global Insight/DRI	SFY00 to CY06	Currently Available
Increase in Fee Schedule Payments — Budgeted		CY06	Currently Available

MERCER

Government Human Services Consulting

Mercer Government Human Services Consulting 3131 E. Camelback Road, Suite 300 Phoenix, AZ 85016-4536 602 522 6500